



Kansas Health Policy Authority Updated

House Committee on Social Service Budget

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Kansas Health Policy Authority Overview

The Kansas Health Policy Authority shall develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion oriented public health strategies (KSA 75-7404)

KHPA administers:

- Kansas Medicaid and the Children's Health Insurance Plan
- MediKan (state funded program for disability applicants)
- Kansas State Employee Health Plan
- Kansas State Workers Compensation fund
- Health care database that includes Medicaid, CHIP, state employee health data, and the state's private health insurance database



Medicaid at a Glance



Medicaid and CHIP in Kansas

Medicaid (Title 19) and the Children's Health Insurance Program (CHIP, or Title 21) are federal-state programs that provides health and long-term care services to certain people with low incomes, e.g., pregnant women, children, parents, the elderly and disabled.

Nearly all health care services purchased through KHPA are financed through a combination of state and federal matching dollars through Title 19 (Medicaid) or Title 21 (CHIP).

Historically, the federal government has picked up 60% of Medicaid costs and 72% of CHIP costs. The Federal stimulus bill raised the Medicaid percentage to around 70%.

Medical services for low-income parents, pregnant women and children are provided through managed care, which we call our "HealthWave" program.

Medical services for the elderly and disabled are largely un-managed.

About 330,000 Kansas were enrolled in these programs in December.



Kansas Medicaid and CHIP: Eligibility Standards and Premiums

- Medicaid: Free coverage for very-low income families, elderly and disabled
 - Pregnant women and infants up to 150% FPL
 - Children: 100% or 133% of FPL, depending on age
 - Elderly and Disabled: income limits vary, 100 – 200% FPL
 - Adult Parents and Caregivers: appr. 30% FPL
 - “Medically Needy” – Adults with incomes above threshold with large medical bills
 - Childless adults are not covered
- CHIP
 - Income limit: 250% of 2008 FPL (appr. 241% current FPL)
 - Premiums: \$20 - \$75 per-family, per-month, depending on income (CMS will reject a state plan amendment to raise these by \$40-100 per month)
 - “HealthWave:” State contracts with MCO; pays flat, capitated rate for each beneficiary – also serves 141,000 Medicaid children and parents



Brief Summary of the ACA



Affordable Care Act: Presumed Objectives

- **Define health insurance coverage**
 - Minimum coverage includes standard benefits and implies affordable cost-sharing
 - Includes prescription drugs and mental health parity
- **Secure access to an offer of group-like insurance coverage for everyone**
 - Eliminates differences in insurance premiums due to the health risks of individuals or co-workers
 - Private, portable insurance for those buying as individuals and employees
- **Get insurers to compete with each other rather than consumers**
 - New exchanges should facilitate price shopping and ease enrollment
 - Stabilize private insurance markets through required participation
- **Buy or subsidize minimum coverage to ensure affordability**
 - Greatly expand Medicaid to cover the lowest-income Americans
 - Cost-sharing protections and Federal tax subsidies for premiums aid others



Affordable Care Act: Private Insurance

- **Changes taking effect within six months**
 - New, temporary re-insurance pool for early retirees
 - Create new high-risk pools for those with pre-existing conditions
 - Provide dependent coverage for children up to age 26 for all policies
 - Eliminate lifetime limits on dollar value of coverage
 - Prohibit insurers from retroactively dropping coverage except for fraud
 - Prohibit pre-existing condition exclusions for children
 - Up to a 35% subsidy for small employers (under 25) to provide insurance
- **Changes taking effect in 2014**
 - Guaranteed offers of insurance to all eligible consumers
 - Eliminate any premium differences based on health risks or gender and limit age-rating to a premium ratio of 3-1
 - Income-related subsidies for both premiums and cost-sharing
 - Create new insurance marketplace through “exchanges”



Affordable Care Act: Health Insurance Subsidies

- **Sliding scale premium subsidies based on income**
 - Under 150% FPL: Max. of 2-4% of income
 - 150-200% FPL: Max. of 4-6.3%
 - 200- 400% FPL: Max. of 6.3-9.5%
- **Cost-sharing protections based on income**
 - Under 150% FPL: Max. of 6% of covered costs
 - 150-200% FPL: Max. of 15%
 - 200-400% FPL: Max. of 27-30%
 - Separate income-related out-of-pocket caps
- **Insurance reforms, subsidies, and cost-sharing protections interact**
 - Some out-of-pocket costs shift into premiums
 - Raw premiums for young adults will go up
 - Young adults are most likely to qualify for subsidies and protections
- **Federal government bears limited risk for premium increases**
 - After 2014, increases in subsidies will be limited to growth in income
 - After 2018, subsidy growth will also be tied to inflation



Affordable Care Act: Medicaid Expansion

- Maintenance of effort for Medicaid eligibility: current Medicaid eligibility rules are set in stone (only until 2014 for adult eligibility above 138% of poverty)
- Medicaid is expanded in 2014
- All non-disabled under 65, up to 138% FPL (includes childless adults)
- Feds cover 100% of cost for expansion group in 2014 through 2016
 - 2017: 95%
 - 2018: 94%
 - 2019: 93%
 - 2020 and thereafter: 90%
- Some state flexibility in covered benefits for newly-eligible
 - Must meet minimum standards set by Federal government
 - Minimum standards may entail new benefits like “habilitation” and “rehabilitation”
 - ACA language indicates that states can opt to provide additional benefits to the expansion population



Affordable Care Act: Children's Health Insurance Program

- Require states to maintain current income eligibility levels for children in Medicaid and CHIP until 2019
- Extend funding for CHIP through 2019
- Benefit package and cost-sharing rules continue as under current law
- In October 2015, federal CHIP match rate increased by 23 percentage points
- Federal allotments for CHIP funding remain in place, limiting potential enrollment
- Eligible children who can't enroll due to limited funding will be eligible for tax credits in the state exchanges



Analysis of Potential Impact on Kansas



ACA State-Level Estimates: Sources and Process

- **Coverage and basic cost estimates produced by *schramm-raleigh Health Strategy* (now *Optumas*) with funding from the United Methodist Health Ministry Fund**
 - Additional analysis of impact on state spending by KHPA
- **Results are consistent with national estimates by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS)**
 - 6% residual rate of un-insurance (rate for Medicaid eligibles was raised to 4%)
 - Small net impact on employer-sponsored coverage
 - Small positive impact on total health spending
- **Estimates include increased cost of program administration**
 - 5% of gross increase in spending; matched by the Federal government at 50%
- **Estimates expressed in constant dollars using 2011 as a base**
- **Limitations**
 - Estimates reflect impact on under-65 population only
 - Estimates do not reflect reductions in Medicare payments included as funding sources in health reform legislation
 - Do not replicate other analyses of the impact on Federal taxpayers



Affordable Care Act: Impact on State Spending in 2020

State options regarding direct spending for the safety net*

	Maintain all state spending on the safety net	Reduce state spending on the safety net by half	Eliminate state spending on the safety net
Point estimate plus 5% provider rate increase	\$35 M	\$12 M	-\$8 M
Upper bound estimate of coverage	\$7 M	-\$16 M	-\$35 M
Point estimate	\$4 M**	-\$19 M	-\$39 M

Additional risk: +/- \$15 million variance in true cost of Medicaid benefit package. Impact subject to state choice and federal regulation over covered benefits.

*Options are illustrative and do not reflect the opinions of KHPA staff, nor the KHPA Board. State spending totals for the uninsured through the safety net are preliminary (\$40-\$45 million annually) .

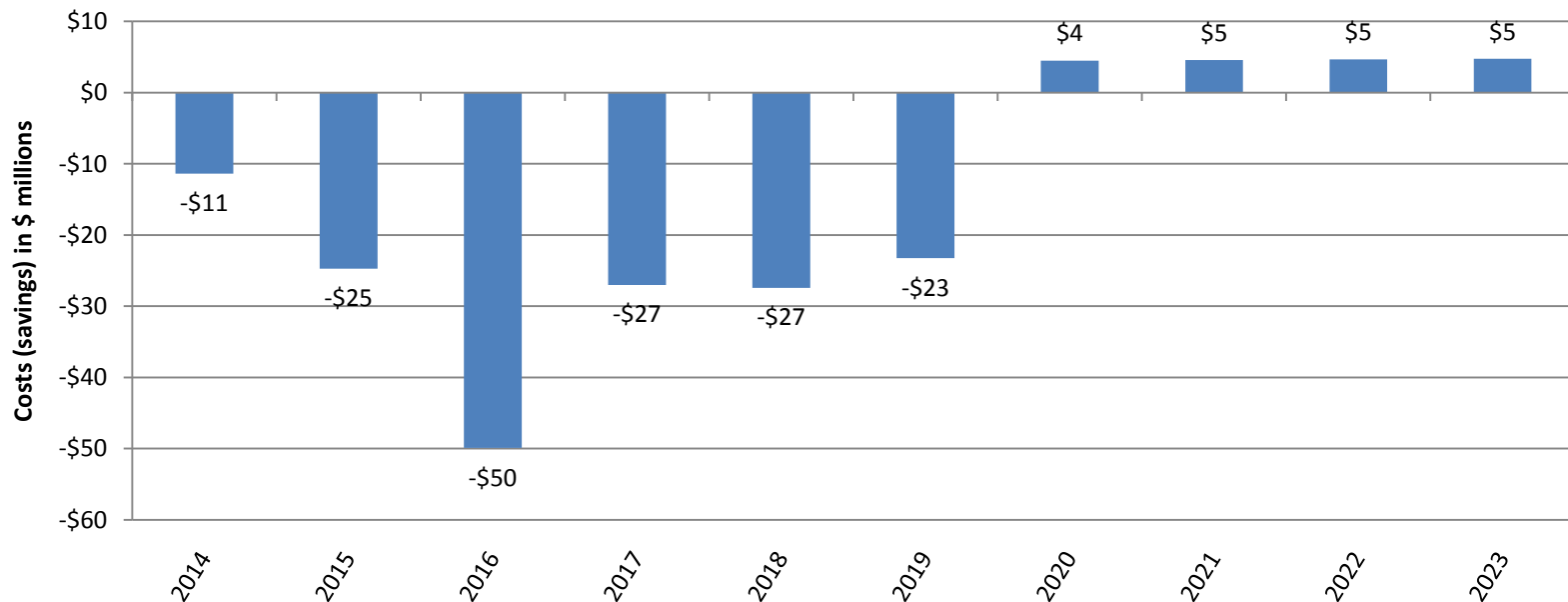
**To the estimate from the actuaries model, this adds new administrative costs and reductions in DSH spending.



Affordable Care Act: Net Impact on State Spending 2014-2023

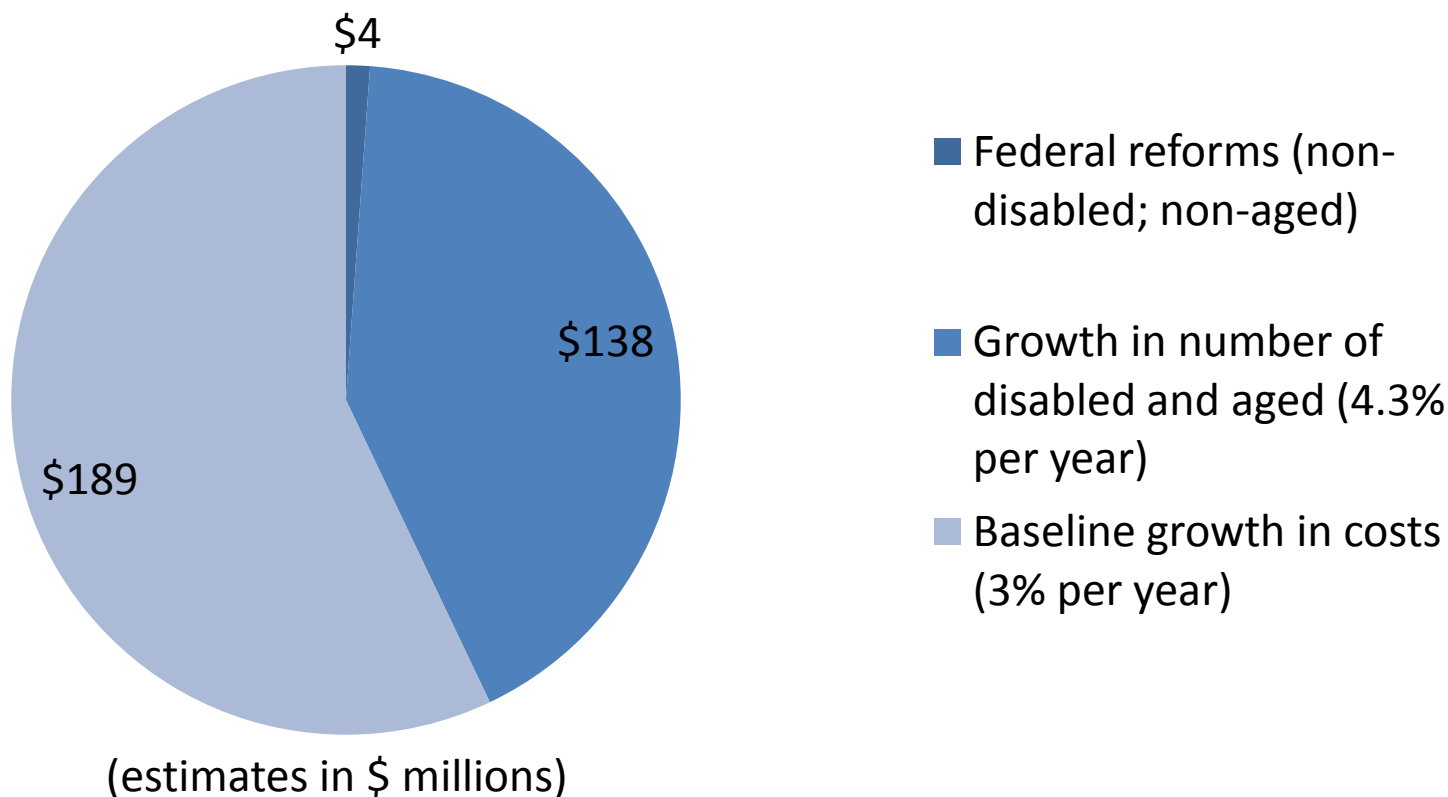
Net Impact of Federal Health Reform on State Spending:

Point estimates: no additional reduction in State spending on the uninsured



Note: Reflects point estimates. Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.

Sources of Growth in Medicaid Spending 2011 vs. 2020



Note: Assumes no additional reduction in state spending on the uninsured, and no increase in Medicaid provider rates.



Affordable Care Act: Implications for Medicaid

- **Expanded role for Medicaid in funding the safety net**
 - Medicaid will become the major payer for some providers
 - Approach to payment and cost control will be more important
- **Reduced turnover among Medicaid beneficiaries**
 - Higher, uniform income threshold will increase continuity
 - Larger, more stable Medicaid population increases financial returns to the state for investments in prevention and care management
- **States will need to re-evaluate programs designed for the uninsured**
 - The state helps mitigate uncompensated care through Medicaid disproportionate share hospital (DSH) payments, direct state subsidies to health care and mental health clinics, special Medicaid reimbursements to clinics and critical access hospitals, etc.
 - Health reform will bring at least \$150 million in new health spending in the state
 - Many of the remaining uninsured will be eligible for subsidized coverage
 - Cultural expectations for coverage and individual responsibility may change
 - Key questions:
 - ❖ How much of current state spending on the safety net is devoted to the uninsured?
 - ❖ How much uncompensated care will remain?
 - ❖ What is the state's ongoing responsibility for those costs?



Affordable Care Act: What It Does Not Do

- **Change individual *health behaviors***
 - Directly confront the true cost drivers in health care: smoking, over-eating, inactivity
 - Make sure individuals face the right incentives as consumers of health care
- **Reduce *health care prices* for consumers**
 - Expand the number of providers to create more price competition?
 - Fill in “missing” provider markets with changes in training and/or licensing?
 - Enact malpractice reforms?
- **Reduce *public spending* on health care**
 - Public spending on health care is unsustainable at the present rate of growth
 - In Kansas, increases in public spending will be driven by the existing program
 - Will require changes in the delivery of care, e.g., technology and coordination
 - Federal reform created new opportunities, but leaves concrete steps to states



Implementation



Affordable Care Act Implementation: State Responsibilities

- **Implement insurance reforms**
 - decide whether to accept the responsibility and opportunities that come with the establishment of an exchange
 - define what kind of competition they want inside the exchange
 - decide how to govern these new and potentially dominant health insurance markets
 - decide whether, and how, to use the buying power and regulatory influence they have been given in Federal legislation
- **Coordinate Medicaid and the new exchange(s)**
 - ensure access to coverage
 - seamless transitions between different sources of coverage
 - link Medicaid's insurance market with the new private insurance market?
- **Determine Medicaid's new role in the health care system**
 - simplify eligibility and select benefit package for Medicaid expansion group
 - set Medicaid payment rates and secure access to providers
- **Respond to numerous grant and demonstration project opportunities**



Affordable Care Act Implementation: KHPA Priorities

- **Closely monitor and work with federal agencies**
 - Federal health reform panels
 - National Association of Medicaid Directors
- **Understand and describe reform**
 - Estimate Potential Impact on Kansas (May 2010)
- **Coordinate information system changes**
 - Build a new platform for Medicaid and the Exchange (RFP released October 2010)
- **Detailed analysis of state policy choices under the ACA**
 - \$250,000 in grants from five Kansas grant makers (matched 1-for-1)
 - Create options for Medicaid benefit packages and to simplify Medicaid eligibility (RFP for contract analysis pending; analysis due mid-2011)
- **Coordinate planning for the exchange with Kansas Insurance Department**
 - Develop Innovator Grant application with KID (submitted December 21, 2010)
- **Solicit input from stakeholders and inform policymakers**



Implementing the ACA: Transforming the Eligibility Process

Implementing the Affordable Care Act: The Eligibility Challenge

- **Twice the scale.** The state needs an on-line real-time system to support eligibility determinations for 33% larger Medicaid population and another Medicaid-sized exchange population receiving at least \$600 million in income-based premium subsidies annually.
- **One-third the time.** Business process must support enrollment of the expanded population in an annual “open enrollment period.”
- **Perfectly integrated.** The ACA requires a single, integrated application and enrollment process for health insurance provided through Medicaid and the exchange, that communicates in real time with a federal information portal (IRS, Homeland Security, SSA, other federal programs).
- **Ready in three years.** First open enrollment starts October 2013.

Assessing Kansas' Readiness for the Eligibility Challenge

- Combined “system” for Medicaid, cash assistance, food stamps, and child care often doesn’t speak with itself
- Aging mainframe system has “hardening of the arteries”
 - Programs written in a dead language
 - Paper applications are required: mail-in or hand carry
 - Labor-intensive reviews and work-flow management
 - Off-system calculations and “work-arounds”
- Very difficult to support additional eligibility categories
- Lack of a simple consumer interface limits outreach
- Can support on-line electronic adjudication of eligibility for neither Medicaid nor for subsidies in the exchange
- “Scalable” neither in the complexity nor the size of programs it can support
- Tens of thousands of un-enrolled eligible individuals

Kansas' Solution: HRSA Grant to Pave the Way

State Health Access Program (SHAP) Grant from Health Resources and Services Administration (HRSA)

- Final grant in a series of HRSA/SHAP grants
- Kansas previously had 2 SHAP grants, documenting the over-riding problem of eligible, but un-enrolled children
- Grant is to provide support for starting up programs that extend coverage to the uninsured population
- SHAP grants will demonstrate, proof-test, and de-bug key elements of federal reform

KHPA's project to cover the uninsured

- Awarded multi-year grant in September 2009
- Includes funds to build IS base for modern approach to outreach
- Out-stationed eligibility workers to recruit and train community outreach partners
- Pilot expansion of coverage to young adults



Planned Eligibility System for Health Insurance Coverage

HRSA grant objectives

- Create full “vertically integrated” eligibility system for Medicaid and the exchange
- Create online application for Medicaid/CHIP and presumptive eligibility screening tool for community partners
- Use full electronic adjudication to reduce error and increase the number and speed of determinations

Additional objectives related to the ACA

- Provide a base for seamless eligibility determinations between health insurance products including subsidies for participants in insurance exchanges under the ACA
- Provide platform that can be used as a building block for the future Medicaid Management Information System (MMIS) – approximately 2015
- Work together with human service agency (SRS) to create a common, flexible platform that could be used (later) to build an integrated process for administering and coordinating means-tested programs, e.g., cash assistance & food stamps



Medicaid Cost Containment Activities



FY 2012 Budget initiative: Recovery Audit Contract

Cost Recovery Audit Contract

The Kansas State Legislature in the 2010 legislative session passed legislation (House Substitute for Senate bill 572) directing the Kansas Health Policy Authority establish a pilot project for Health Care Cost Containment and Recovery Services to be implemented regarding programs of state agencies or programs responsible for payment of Medicaid or State Employee Health Plan medical or pharmacy claims .

The state further provided that the pilot project be implemented in such a manner as to coordinate with the federal requirements to establish a Medicaid Recovery Audit Contract pursuant to the federal Patient Protection and Affordable Care Act, H.R. 3590 (ACA).

The RAC Program's mission is to reduce Medicaid and CHIP improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the identification of actions that will assist KHPA in preventing future improper payments.



FY 2012 Budget initiative: Recovery Audit Contract

Cost Recovery Audit Contract

RFP was developed with all agencies input, closed on October 29.

Bidders required to guarantee at least 90% of projected recoveries to ensure legitimate bids and enhance competition.

KHPA awarded the contract to Health Data Insight (HDI) in early December.

HDI to find overpayments and recover excess funds.

HDI promises a minimum collection of \$16.08 million yielding \$5.3 million SGF over the FY 2011-2013 period (net of contingency fees).

Recoveries are expected to exceed the contractor's guarantees.



Medicaid Cost Containment Initiatives

Cost Savings/Efficiency Request for Information.

KHPA solicited Medicaid cost-saving ideas in an open call in February 2010. Dozens of ideas were summarized in a Medicaid savings options report submitted to the legislature.

KHPA hosted a Forum on Cost Drivers in Medicaid April 26, 2010 for stakeholders, providers, state agencies and legislators to identify sources of growth and discuss potential solutions.

Developed a Request for Information to seek products and services from vendors that could reduce Medicaid costs (responses were due October 29, 2010). *See Attached Summary.*

The Lt. Governor is leading an effort to be spearheaded by the HHS Sub-Cabinet to remake Medicaid. The Administration is soliciting ideas for pilot programs and reforms to curb growth, achieve long-term reform, and improve the quality of services in Medicaid. (Responses are due to KHPA February 28)

*Coordinating health & health care
for a thriving Kansas*



<http://www.khpa.ks.gov/>